Louisiana Department of Health and Hospitals
Office for Citizens with Developmental Disabilities

Request for Services Registry
Information Form

Individual's name: _____ Date of birth:_____

Individual's social security number: _____

Individual's mailing address: _____

_____

Individual's physical address: _____

_____

Individual's phone numbers: _____ _____
(day time phone) (night time phone)

Name of family member/authorized legal representative:_____

Relationship to individual: _____

Family member/authorized legal representative mailing address: _____

_____

Physical address: _____

Family/representative's phone numbers: _____ _____
(day time phone) (night time phone)

Do you have a Medicaid card: YES NO (please circle)

Medicaid number: _____

Signature: _____